STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING _____ B. WING _____	C 08/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE RETIREMENT HOME	**4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00094448 and IN00094462. Complaint IN00094448 - Unsubstantiated, due to lack of evidence. Complaint IN00094462 - Unsubstantiated, due to lack of evidence. Survey Dates: August 29 and 30, 2011 Facility Number: 001144 Provider Number: 155668 AIM Number: 200256980 Survey Team: Gloria J. Reisert, MSW/TC Dorothy Navetta RN Census Bed Type: SNF: 59 SNF/NF: 60 Residential: 06 Total: 125 Census Payor Type: Medicare: 23 Medicaid: 42 Other: 60 Total: 125 Sample: 08 Providence Retirement Home was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00094448 and IN00094462.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PROVIDENCE RETIREMENT HOME	**4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150**

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F 000	Continued From page 1 Quality review 8/31/11 by Suzanne Williams, RN	F 000		